Developmental Disabilities Nurses of New Hampshire

www.dhhs.nh.gov/dcbcs/bds/nurses

DDNNH@dhhs.state.nh.us

Minutes

January 20, 2015

1. **Meeting was called to order with 22 in attendance, one member trialed attending by phone**

2. **Review** and approval of December 2014 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted. Rivier University scholarship discussion - $250 given in the past, group voted to commit to same amount again. DDNA conference for liaison discussion – group committed to providing $545 towards the conference fee (historically this has been the total amount for the preconference day plus the conference at the early registration rate).
   b) **DDNA liaison report:** .Martha Fenn King told the group that she spoke with Mary Alice Willis, prior DDNA executive director, in December and was informed that the HealthSoft CEU access will be removed from the DDNA membership benefits.

4. **Business Discussion:**
   a) self med (admin) assessment – one member raised a clarifying question – is the deadline for the reassessment to the end of the 12th month – answer – yes.

   b) **eStudio discussion** – who should have access to the DDNNH folder? One suggestion raised was to limit it to paid members of DDNNH – ultimately this was not chosen. Access to eStudio DDNNH folder will be limited to nurse trainers who are either actively working as NT or seeking a position as a NT. Therefore, Kiki will not have access to the folder in her current position with OOS. Cheryl Bergeron volunteered to be responsible for sharing relevant communications from the DDNNH group to OOS. This will allow flow for our ongoing collaboration to continue.

   c) **FAQ –** group agreed that the work done on the FAQ updates could be posted to the website after format polishing and a few small word changes. A member asked that we be clearer in our use of phrases – some say self medication assessment others say self administration assessment. Self med assessment in some practices specifically means what drugs is the individual choosing to self medicate with – including off label practices, alcohol and street drugs. Therefore the most accurate phrasing for our work would be self administration assessment.

5. **HRST discussion excerpts with Denise Sleeper:**
   Denise shared her appreciation for the information that NTs provided about HRST and the draft protocol (referring to the collation of info sent in December).

   Information learned from HRST makes a difference in a person's life and processes to ensure that are being developed.

   HRST is a tool designed for a non health care worker to complete and identify any health related gaps.

   NT is not required to be the point person.

   Service coordinator needs to identify who the most knowledgeable person is – when completing or updating the HRST.

Every Area Agency needs to identify a HRST point person – to ensure raters are trained, processes to implement use of the tool are developed and followed. This point person will be able to determine who needs to have what kind of access. e.g. what access do you have? There is a view only option. This point person will also be responsible for ensuring that there is an accurate log of individuals on HRST – because each area agency pays per individual.

Each Area Agency will be responsible to develop policy to determine who is responsible for what in HRST.

HRST 101 – basic training – looking to be on Relias – which will allow tracking of who has received HRST training.

One member shared – 4 HRSTs due – with deadline of: if not done by Monday this person will be homeless. Service coordinators are leaving off 4-7 diagnoses, incomplete medication section. Denise responded that the deadline imposed upon that NT is NOT the state expectation. It is the area agency's responsibility to have processes in place to emergently serve people who are eligible for services and at risk of becoming homeless.

The HRST protocol (for NH) has bolded **screening** as a reminder that this tool is not an assessment.

Forthcoming changes – there will be a system enhancement on HRST - when a change is made an email will auto happen. One member asked will the auto email notification go both ways – from rater to RN and from RN to rater. Good question – answer unknown, Denise will ask.

Another member commented – oversees individuals receiving services in several regions – for her caseload's biggest region she has no access to HRST for those individuals.

Monthly data tracker – grid for DSP – check off only. Give monthly to service coordinator if there are marks on it and then RN may need to be involved.

Recommendation that DDNNH discuss/compare – HSI and monthly tracker – are there actual overlap items, can the HSI not be used? Are the target populations the same? Where does HSI have content that could be helpful for HRST?

One member commented – the program is not user friendly. Doesn't address: pain, mental health. Feels like it doesn't reflect our individuals and their real lives.

Denise – we haven't given the tool an effective run in implementation to effectively change health outcomes – because as it stands now, our current system is not helping health outcomes as it is (this if based on national health outcomes measures –people with DD compared to people who don't have DD- is there equitable health care access).

Please itemize feedback to the Bureau about specific challenges with using HRST.

Service coordinator group meeting scheduled for Wednesday (1/21) to discuss protocols and systems for HRST implementation.

Area Agency level HRST protocol that Denise has referred to today – Cheryl will share current draft with the group.

Billing – every AA has a monthly contract for $3/mo/person ($36 per person per year) for everyone in HRST. The Area Agency has an opportunity for additional billing when HRST completed - $100/yr

Please consider how HRST could be a better benefit to us – if "x, y, z" were included. RNs could be helpful in reviewing and developing benefits.

CMS has bought into (expectation for use of) HRST implementation in NH.

Next Meeting will be February 17, 2015.

Submitted by: Jennifer Boisvert, RN, Secretary, DDNNH

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Minutes

February 17, 2015

1. **Meeting was called to order with 23 in attendance**

2. **Review** and approval of January 2015 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted. Because Wayne Ward was not present at the meeting, the question was raised for whether he would be able to attend the DDNA conference on DDNNH's behalf in May. Jen asked if anyone was present who had talked to him. Joy Kempton said that she could ask him: if he will be able to go to the conference and whether he has done the network report that was due at the end of January.
   b) **DDNA liaison report:** Jen commented that an email had come out from DDNA with a link to a newsletter – only available to members, but the login didn't work. Other DDNA members present agreed that they couldn't log in. Jen sent an email to DDNA Monday evening. Martha Fenn King noted that she has seen a website under construction notice on DDNA's page.

4. **Business Discussion:**
   a) HRST teleconference – Erin was unavailable to host after our February meeting. Cheryl is in process of attaining a new date. Discussion with those present when preference requested (group experience or from our own computers) – there is a preference for a group experience. Cheryl will try to get a commitment from Erin for after the next meeting (March 17) and if not, then a date will be chosen so that we can participate in this discussion without too much more time passing. The purpose of the teleconference is to openly voice concerns that NH nurse trainers have about HRST in their practice – so that answers can be shared or developed. If the new date is not after a DDNNH meeting, people will be welcome to come to Concord to participate and others will be welcome to participate from their own location. Details will be sent out via email about the date/time. Jen volunteered to send out an email soliciting questions for Erin prior to the meeting – and will post those provided in eStudio.
   - Cheryl said that the plan for roll out of the auto email within HRST when a change is made in a file is scheduled for May/June.
   - One member stated that she feels like she is winging with HRST – she has completed/attended all of the trainings and still feels unprepared.
   - A couple of members questioned why antidepressants are listed in HRST as causing tardive dyskinesia – they have unsuccessfully requested the references to back this up (from HRST). Some members did not know how to find the list of medications in a person's HRST profile that the tool assigns as TD causing.
   - Question was raised – how do we know that the information within HRST is entered correctly (where is it coming from, a reputable source?)?
   - One member who works with an agency providing services to individuals in many regions – says that in one region the CM requests updated med lists signed by the physician – no one else present had had that experience.
   - One member asked if it was possible to have the individual's accurate health information linked through a database to HRST. No one present is aware of anyone who has a current electronic system that could do this. It is an intriguing idea – and would require standardization acceptance across regions – which has been a challenge in other areas of service.
   - One member's major ongoing concern, then echoed by others present, is about the liability of the RN reviewer – how is it that we don't have liability – when we are signing off on information entered by someone else without the ability to verify the validity of the entered information.

b) HSI and monthly data tracker tool comparisons – this was suggested at January's meeting – not something that the group as a whole wants to work on during a meeting. No consensus reached on how to accomplish this comparison. A suggestion was raised to create a "parking lot" section on the monthly agenda.

- One member noted that on the HSI there is no column/question that talks about how the individual communicates – so she adds it on the bottom of the form. This member also said that she had difficulty finding a place on HRST to note if the person is continent or incontinent – Jen suggested Item D – toileting.

c) A member commented that there seem to be new requirements coming forth that require an increase in time spent on checklists and other documents that don't seem to improve the quality of services that the individual receives. Specifically at her agency, she believes that they have a very comprehensive health related system that has been developed and in place without these new tools – yet the new tools are required and deficiencies are received for missing tools.

- Discussion ensued about the tools themselves not being mandated. The regulation requires certain things be clearly documented. For example the regulation lists 9 areas of consideration for annual health screening – the associated provided document isn't mandated – an agency can use another means of documenting that these areas were addressed during the annual health assessment.
- One member stated that she understood that the frail worksheet was required – members answered that the tool is available but not mandated. What is mandated is that the NT document that a frail assessment and outcome has been completed.

d) 525 discussion – Martha asked what experiences people present were having with 525 – are you using NUR 404 and how. She had seen an item in the FAQ update about yearly assessment and 525 was one of the regulations listed though there is nothing in He-M 525 that requires this yearly assessment.

- The specific FAQ item was unspecified – when an item lists 525, then the underlying presumption is that He-M 1201 applies. If NUR 404 is being used for these settings (with staff), then the delegation rules are what needs to be followed. When He-M 1201 rules are being used, then 1201 rules need to be adhered to.
- The family situation that made this consideration arise – uses a Phillips medication dispenser – the family sets it up. It's sophisticated, requires a phone line. The individual could not be successful with self administration without family support. NUR 404 is used in this program – does annual assessment per He-M 1201 apply? No – only applies if the program is using 1201.

e) How long is a PRN order from an ER visit good for? Individual had an order in the community for Motrin 400mg q 4-6 hours for back pain. Pain increased despite use and individual was taken to ER. ER prescriber ordered PT and increased Motrin to 600mg q 6-8 hours – gave 30 tabs, no refill.

- Discussion centered on – this new order supersedes the previous order, the PRN protocol needs to reflect the change, best practice to inform original prescriber of the change.
- This order is good for a year – though, depending on your practice, you may not be able to get supply for that long (in this case only 2 pills were used).

f) Falls prevention series info – included on agenda, uploaded in eStudio. Focus is on geriatrics not individuals with DD or ABD – still may be useful info.

g) A member asked – is there an update on NHH, Lakeview etc? What are we going to have for resources – example – individual living in a group home for about past year. Funded out of one region, physically placed in another and his PCP is in yet another. He has 4 psych meds and no psychiatrist. At Qa RN noticed some EPS symptoms – did assessment and delved deeper into what else was going on with this individual which resulted in the development of a list of issues that need to be addressed: has glasses but they are broken, he's having problems hearing – ears are full of wax – get a ENT consult, difficult time showering – ortho, environmental mods, needs a psychiatrist. He has a new service coordinator.

- Area agencies are in discussion for a plan, for resource development. No specific news shared about Lakeview, NHH.

Next Meeting will be March 17, 2015.

Submitted by: Jennifer Boisvert, RN, Secretary, DDNNH

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Minutes

March 17, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of February 2015 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.
   b) **DDNA liaison report:** New website went live online last week. Annual conference is coming up – May 1-4 in Atlanta, GA. Poster session submission request – no one volunteered to make this happen. Nominations are open for treasurer for Board of Directors. Wayne is not able to attend the conference – DDNNH scholarship open – discussion about how the manage this within the deadline time constraints – decision made for Jen Boisvert to receive the scholarship (and responsibilities) for this year's DDNA conference. Jen says: "thank you all for your vote of confidence and kind words during our discussion".

4. **Business Discussion:**
   a) HRST teleconference – comment responses of attendees varied. Some are still OK in the process of where we are. Others raised concerns about out of date RN knowledge and remaining unconvinced that inaccurate information input by rater doesn't impact liability.

   b) Cheryl provided copies to the group of the HRST protocol released from NH DHHS on March 13 to the Area Agencies.

   c) Peter Bacon - discussion points raised:
   - An individual is new to 1001 services – they have no meds – question from Area Agency – how do we document? Answers from today's attendees: use either the transition form and/or self administration assessment.
   - Is self administration assessment annual or PRN? Answer – at least annual
   - He-M 507 self administration assessment? No meds while at the program, does get meds at home, never in 507 setting.
   - If individual is assessed as not able to self administer, does annual assessment need to be done? No.
   - Individual moves from home A to home B – everyone is the same except the actual address – is mod 4 needed (e.g. does NT need to re-observe all authorized providers in new home)? Answer: no, unless there is a question of competency. The NT needs to update the medication certificate(s) – could be a new start date, same end date or could be copy of old cert with notation of new address.
   - How do you destroy meds? Meds were flushed – would there be a deficiency cited? No citation because this is not specifically addressed in the regulations. Many present offered the recommendation that we should never be flushing meds – they should be crushed and mixed with something (e.g. used coffee grounds).
   - Med committee may ask about how do you (the NT) keep a large number of authorized providers current (e.g. 4 individuals – 29 authorized providers). This raised a side comment about how many sites can an authorized provider safely stay up to date – this is from an old version of the regulation – it used to say 8. Now the regulation is silent – the individual agency can set parameters. The NT needs to have a process in place and be able to articulate it.
   - Situation – in a 1001 setting – 300 Ativan in a bottle – haven't used for past year, supply is unexpired. Discussion around destroying a portion, preparing authorized providers to not stockpile or ask

pharmacy for a partial fill (which we know pharmacies do not prefer to do – but will usually do when asked).

d) Penny – HB #2 item #62 proposed to consolidate joint boards of licensures – contact your legislature members. Information is available on NHNA webpage. If this happens, at the very least licensure fees will increase. Links: original bill - http://cqrcengage.com/nhnurses/app/bill/520213 NHNA call to action update - http://www.nhnurses.org/Homepage-Announcements/News-and-Announcements/HB2.html

e) HRST newsletter sign up – If you are a NH RN and not already receiving the newsletter – send a requesting email to: gina@hrstonline.com

Next Meeting will be April 21, 2015.

Submitted by:
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MINUTES

April 21, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of March 2015 minutes as written.

3. **Officers Reports:**
   a) **Treasurer's Report**: Read and accepted.

4. **Business Discussion:**
   a) HRST discussion continued. Cheryl passed around flyer on HRST 3.0 upgrade. There will be a webinar on Friday 10:30 – 12:30 demo'ing the changes – space is limited. People who indicated interest in participating (outside of the subcommittee looking at redundancy in forms) see Cheryl at the end of the meeting.

   Looking at frail list and how to eliminate redundant documentation. Looking to figure out a way for a person who is rated HCL 1 or 2 and has diagnosis like asthma or diabetes that generally are OK – until an episode tips them over into frail period. Only nurses would be inserting this piece.

   List of how many people in NH have been HRST rated and/or are still unrated – passed around.

   Common med entry errors – we should be sending back to the rater, not fixing it ourselves. Ellen from Region 2 says that the HRST doesn't allow RN to make changes at their agency so they have to send back to the rater for corrections. This seems to be a permissions boundary at this agency rather than something HRS has put in place.

   Cheryl – if you as a NT don't have access to your clients' HRST with a particular region – send an email to Cheryl listing who you don't have access to.

   b) Nominations – **DDNA liaison** – this is a yearly position. Debbie Ellis-Nailor, Lynn Geoffrion put their names in for consideration. Wayne Ward was not present at today's meeting, Ellen believed that he would be interested to be considered again. **Treasurer** – Dianne is willing to continue in her position – however, she may not be available for the full 2 years. Liz Nelson volunteered to shadow to learn the position since they work together – this will provide us with someone to fill the rest of the position if Dianne does leave early.

   c) IM Glucagon – Cheryl looked at waivers going back to 2011 – there were only 2 requests. There is a bill at the legislature now about school access – which would be for non nurses to administer.

   Can we waiver this? Do we need to? Depends on whether ordered SC or IM. In 525 example – Mom is trained, wants to have staff – can they be trained?

   Does anyone have IM glucagon? – a few people. Wayne K – efficacy of Glucagon SC vs IM is equivalent.

   Cheryl – there is a known and accepted protocol for when/how to use Glucagon IM. She has some information from other states about use of Glucagon – all info is about IM.

   To all: Please look for Glucagon orders in your program – are they SC or IM? Bring or send info to Cheryl.

   Penny found an app for Glucagon – looks pretty clear, has training: lillyglucagon.com

d) Doc-U-Dose/blister pack – handouts provided. What do you do when there's a med change?

Ellen – has an individual who is self administering – most helpful for people who don't have many med changes. Experience with providing pharmacy is when there is a med change, the supply is taken back and re-packaged, this individual has some challenges with different bottles (if you have added med provided in bottle form until current packaging runs out).

Sherrie – Several individuals use in the Nashua area – only one pharmacy (Hollis Pharmacy) – home care providers that use them – swear by them, do their triple check, there is an additional cost. Pharmacy takes back and repackages with med changes.

Penny – pharmacy has sent bottle for med change, RN took the pill out – means that the RN has to be able to identify the med to take out, manage the small slit etc.

Controlled meds – separate container because of need for counting.

Pharmacies have made errors – mostly at first – increase your communication = resolution. In one case it was because the prior authorization ran out, so the med was not supplied).

Ruth – new pharmacy coming to Manchester through Greater Manchester Mental Health Center – The Moore Center will be transitioning staffed residences. Pharmacy will be sending out only 2 weeks supply at a time.

Pharmacies can provide either 2 week or monthly supplies.

e) BDS audit of NT contact hours per He-M 1201.10(d) and (e) – Cheryl will be randomly selecting 10% of NTs and sending out letter to seek compliance information. There was a general discussion about possible places to get credits.

f) New business discussions:

Eileen – passed around handout from NHNA regarding HB2 – strong advocate for keeping separate BON rather than having combined licensing office.

BON has asked to be removed from the med committee – they have not been sending a nurse, usually a nurses' aide.

Penny – surveyor – made a recommendation about how to count Diastat that was not the same as the NT expectation. Staff almost changed to the surveyor's way without discussing with NT.

May 5 – budget discussion hearing – looking for speakers with stories. Have to register to speak, be prepared for a long wait with understanding that you may not be called to speak, then hand in written testimony.

Nurse practice issue: New order for individual with dementia issue requiring self catheterization. Case manager supported the individual at the appt. Staff at the home is very uncomfortable with idea of even helping with this task – this is a very independent style setting. RN is not comfortable delegating.

Another nurse shared a positive story of individual with autism who successfully self caths.

Suggestion to look into self cath products – there are all in one products available on the market.

WellSense – there have been challenges dealing with them approving medications – particularly noted to be slow with approving antibiotics.

Next Meeting will be May 19, 2015.

Submitted by:
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Secretary, DDNNH

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Minutes

May 19, 2015

1. **Meeting was called to order with 25 in attendance**

2. **Review** and approval of April 2015 minutes as written.

   a) **Officers Reports:** **Treasurer's Report**: Read and accepted with 2 paid today.

3. **Business Discussion:**

   a) IM Glucagon discussion continued – Wayne K was not at meeting today. Med committee discussed – do you need a waiver or not – answer is not if the order is for SC, yes if for IM. No one emailed Cheryl with glucagon orders. 2 nurses present currently have individuals with IM orders and are in process of changing to SC.

   b) Voting – 20 members voted (1 electronically). **Congratulations** to Dianne and Debi - Treasurer – Dianne Crone. DDNA Liaison – Debi Ellis Nailor

   c) DDNA conference – next year is in San Diego, CA. April 1-4, 2016

   d) 2 handouts from DDNA conference reviewed – DDNA's annual membership meeting and letter from nurse researcher (Kathy Auberry) about participating in an upcoming seizure study.

4. **NEPS (Northeast Pharmacy Services)** presentation of their medication packaging system. NEPS was created in 2004, they have worked with many group homes and fielded many questions from assisted living facilities. They looked around for the best packaging system to deliver patient safety. Each person present at today's meeting received a NEPS sample folder and example packaging. NEPS is a closed pharmacy – clients cannot walk in off the street. Packaging is done by robotics and they are paperless. NEPS does post consumption billing. Typically med packages are dispensed 1 week at a time – they send 2 weeks supply outside the Concord area – these are mailed. There can be up to 4 doses in each packet.

   Q: If there is a change in the order what happens? A: NEPS sends a vial with small quantity to get through to the next package cycle. The home would be responsible to remove the dose that is changed. If this is a non critical order – ask the MD to write the order to start when current supply is exhausted. Worst case scenario – 3 week lag to change package.

   Q: antibiotic/critical med – how to manage? A: Example – antibiotic, chronic pain – mail supply out same day the order is received (overnight mailing) – this timing could still be an issue for the patient. Might need to have a local pharmacy if the med needs to start today.

   Q: What is the cost of the service? A: $35 per person charge for NEPS service. CFI waiver can cover fee currently (majority of NTs do not have individuals on the CFI waiver though).

   Q: MCO acceptance of this process? A: MCOs don't know yet, meeting scheduled to discuss.

   Q: PRN meds. A: Handled separately. PRN meds are not automatically sent. NEPS waits to send until asked. Occasionally NEPS will prompt if there is a pattern of usage.

   Q: Camp meds? A: NEPS doesn't package for just camp meds.

Patient/caregiver **MUST** talk with prescribers to clearly say that the **pharmacy of record** is NEPS – so that orders don't go to the local pharmacy.

Concern raised by member re: staffed residences – fear of liability if unlicensed provider is removing dose if order is changed.

Another member asked about how do we ensure triple check process works? Two members discussed their positive experiences – stable meds, not group home. There are a couple of extra steps added. Works great.

NEPS reps – this service is specifically meant for patients whose meds are stable.

NEPS ex. – can split supply if going to dialysis or out with family for the day – all supply is still properly labeled.

NEPS – prior authorizations – can be an issue for billing. If med is dc'd within first 2 weeks of the package cycle – only pay for 2 weeks, not for the rest of the month.

Terri shared her experience with Med World in Nashua – blister pack comes with a sticker – sticker is put on the med log. They have had issues with light sensitive meds and liquids (which can't be packaged). Med World will re-package if you take current supply back. The most useful aspect of this type of packaging – prevents running out of supply.

5. **Peter and Kiki**: Order date that you reference in your med log entry is what you display – age of date doesn't matter. Issue with med log that says 2013, med order itself is dated 2015 – that is a concern.

Q: How long do we need to keep records? A: (from group) 7 years. Although a recommendation from a nurse attorney at DDNA a few years ago was to keep records for 10 years.

Q: Drug info sheets – only need to have ones for current meds in the med log book.

Q: QA when (in 30 days, 1 month) after respite in certified home? A: Old regulation required within 1 month. New reg is at NT discretion.

MFK – He-M 525 has paid staff, lives with family – going for respite in 1001 setting – which rule applies – 525 or 1001? Do we follow the money? A: Peter says can have certified bed for fire code. Doesn't matter for meds – follow the money rule. Peter and his staff don't look at any records for individuals in 525 settings – not in their purview. Peter reminded us that there are currently certified homes that have 1001 certified beds and the same home also provides services for an individual with 525 certification.

Q: How does a NT manage their practice when 1001 and 525 services are provided in the same setting? And there could be 2 agencies responsible for the individuals receiving services. A: Develop a moral best practice.

Q: RN with current license and pharmacist with current RPh – if coming in to administer meds in certified setting – so they need med training? A: No – need copy of license – license needs to be active and in good standing. If they do not want to administer meds using their license, then they do need to be med trained.

Q: compliance form – is it required? A: No – no specific form is required/mandated for any of our work – except 1201 A, B, and C forms plus waiver forms.

Kiki – HSI – not documenting that review is occurring.

Q: Member asked about medically frail – how does NT oversee? What frequency? A: Your agency decides. Related discussion point - Medically frail worksheet – goes to CM/SC – doesn't need to be sent to Cheryl.

Peter's next visit – September meeting.

Next Meeting will be June 16, 2015.

Submitted by:
Jennifer Boisvert, RN
Secretary, DDNNH